

Retirement *and your* Health Insurance

A Guide to
Making *Your*
Best Choices

- *How retirement affects your health insurance*
- *How employment-related benefits coordinate with Medicare*

**PART OF THE
CONSUMER GUIDE SERIES**

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ADVISORS (SHIBA), A FREE PUBLIC SERVICE SPONSORED BY
THE OFFICE OF INSURANCE COMMISSIONER DEBORAH SENN

A message from Insurance Commissioner Deborah Senn

Dear Consumer:

As they approach retirement, many Washingtonians are concerned about how their health benefit plans from current or former employers—“employment-related benefits”—fit into the health care coverage picture. Before and after you retire, there are issues to consider and choices to make regarding Medicare and other health insurance.

My office has published this Guide to help you know when “employment-related benefits” are sufficient; when other solutions should be considered to ensure adequate protection; how employment and retirement affect Medicare eligibility, enrollment periods; and other key issues.

Use this Guide to find out:

- whether your employment-related benefit plan will be enough—*now and later*
- whether your employer’s plan will bridge gaps between Medicare coverage (when you become eligible) and actual health costs
- about alternative solutions for providing the coverage that Medicare—or your employer’s plan—doesn’t
- where to go for further assistance, information and guidance.



We also publish other health insurance guides to educate and assist consumers. A list of these and other resources is printed on the inside back cover of this publication.

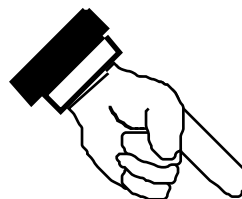
Also, please take full advantage of the expertise our Statewide Health Insurance Benefits Advisors (SHIBA) volunteers can offer you. Their advice is *free* and completely objective. No SHIBA volunteer has any affiliation with any insurance company or product.

Dial toll-free: [1-800-397-4422](tel:1-800-397-4422) for the number of the SHIBA agency nearest you.

Best wishes and good health,

Deborah Senn,
Washington State Insurance Commissioner

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ISSUE

A.

Understanding employment-related benefits

- **How does my employment or retirement affect my health insurance?**
- **What options are available to me?**
- **What do I need to know to make an informed decision?**

The underlying issue for most individuals is *whether you can or should continue your employer's coverage after you retire*—or whether other coverage would be better for you. The goal is the best coverage possible, at the most affordable price. This may or may not mean keeping your coverage.

Employment-related benefits can also be a satisfactory way to supplement or augment Medicare, once you become eligible—if you are aware of the issues and questions that arise when employment-related benefits interface with Medicare.

What you should know, what steps you need to take, and how your Medicare enrollment is affected depends not only on your company's benefit/retirement policies, but also on where you

and your spouse stand in the retirement process now. *Are you retired, or about to retire? Are you the spouse or dependent of someone retired or about to retire? Over 65 with a spouse not yet 65? Continuing to work after 65?*

Optional *and* mandatory decisions and deadlines differ within each of these categories. Therefore, some of the information that follows is divided into sections that define your status as an employee and/or Medicare beneficiary: [Retiring Before 65](#); [Retiring At 65](#); and [Retiring After 65](#).

You may want to first read the section specifically addressing *your* position in the retirement process (see Table of Contents). However, reading this entire Guide—including the general information that applies to all retirees—will provide important details on how to determine what health benefit options are available to *you*; what questions you will want to ask before making an informed decision; and how *your* retirement situation affects enrollment in Medicare.

This Guide assumes you already have a basic understanding of Medicare and its benefits. You should also be familiar with the 10 standardized Medigap plans A through J, managed care plans, and other health insurance available in your area. For more information, SHIBA publishes the free *Medicare, Medigap, & You* and *Managed Care, Medicare, and You* (see order form at back of this guide). The Health Care Financing Administration (HCFA), which administers the Medicare program, produces *The Medicare Handbook*, the *Guide to Health Insurance For People With Medicare*, and *Medicare and Other Health Benefits*. All of these are free, and can be obtained by writing to the appropriate addresses listed at the back of this Guide.

A brief background on employment-related benefits

Many employers provide benefits for their employees. In addition to benefits such as vacation time and sick leave, many employers provide insurance benefits such as life insurance, long-term disability benefits, and medical benefits for the worker and the worker's dependents. We call these "employment-related benefits."

Some companies continue to provide all or some of these benefits to their employees even after they retire. However, today many such post-retirement benefit programs are being reduced or eliminated due to costs and changing accounting practices.

Therefore, retired or soon-to-be retired workers and their dependents have decisions to make about the health benefits their employers provide, how those benefits may coordinate with Medicare, and how they compare with other options that may be available to them.

In addition, many employment-related benefit plans are subject to federal regulation under the Employee Retirement Income Security Act (ERISA). Federal regulation under ERISA determines how plans are administered and who is eligible.

The most common—and unique—kind of coverage

More retirees are insured through some kind of employment and/or retirement benefit plan (either themselves or through a spouse) than any other kind of medical plan or policy. But since employment-related plans are individualized for each company or organization, there are literally

thousands of them in force, with no two alike.

Your company may self-insure, in which case your coverage is not actually an insurance policy. The plan may be a private managed care plan and not necessarily a Medicare-contracting one; or a *private* "supplement-*type*" policy unrelated to the 10 standard Medigap plans (and thus not subject to the same regulations).

Since the different types of health insurance coverage provided by employers are unique to each company or organization, it is important to familiarize yourself with:

- how your employer's plan is regulated;
- what the employer's policies are regarding post-retirement benefits;
- how regulatory changes could affect your post-retirement coverage.

In addition to basic information, this Guide provides checklists and charts to help you get to know your plan, compare it to alternatives, and determine the most appropriate coverage for you before and after retirement.

It's never too early to plan...

You may be a long way away from retirement right now. And you may be a long way away from enrolling in Medicare.

Still, maintaining high-quality, affordable health coverage after you retire is so important that it's never too early to start thinking about how your work/retirement plans will affect your health insurance.

Some of this process may be easier to manage with the help of a trained counselor. Don't hesitate to contact a SHIBA volunteer for free, objective information and assistance. Instructions for contacting SHIBA are located at the back of this Guide.

Retiring before age 65

If you are retiring before age 65, and you are not eligible for Medicare before age 65 because of disability, you will need health coverage—for yourself, and possibly for your spouse and/or dependents (if they are also younger than 65 and not covered by Medicare or their own employment-related benefit plan).

To ensure that you have adequate health coverage until you become eligible for Medicare, [you should ask yourself these questions if you are planning to retire before 65:](#)

- Is it possible to continue on your employer's plan after retirement? For how long?
- Are insurance rates and plans in the open market more competitive than the cost of continuing on your employer's plan?
- Who pays first and second (i.e., does your plan pay first, or does it pay only the balance of a fee after a spouse's plan has paid?)
- Are your spouse/dependent(s) relying on your employer's plan? If they are enrolled now, will they continue to be covered after you retire? What about after your death? If not, are they covered by their own employment benefits, or eligible for Medicare?
- If you drop your employer's plan, are you covered by your spouse's employment benefits? For how long will that plan cover you (i.e., will spouse keep the plan after retirement, and will the plan still cover you after spouse retires? If not, when will your coverage under that plan end?)

Health coverage alternatives before age 65

Even if you have the option of continuing on your employer's plan after retirement, it may be worth your while to research the alternatives in the open market, as well as to consider how your coverage by a spouse's plan (if applicable) coordinates with your own.

Depending on how your spouse's plan is administered, your coverage by his/her plan may render your own employment plan secondary, so that you are paying for coverage that might never actually "kick in." And thanks to Washington state's health insurance reforms of 1994, the open market offers benefits and guarantees at affordable costs for many residents.

You may want to look into the health coverage alternatives discussed on the next few pages—for you, spouse and/or dependents—before deciding to keep your employer's plan.

[Before making decisions, be sure to read the general section "What to Look for in Your Employer's Plan" on pages 16-17 of this Guide, and use the checklist and chart on pages 18 and 19 to analyze your current plan and compare it to your other options.](#)

[Also, your local SHIBA volunteers offer free, objective and confidential assistance with evaluating these alternatives. See the back of this Guide for more information on SHIBA.](#)

SPOUSE/DEPENDENT ISSUES



If you are retiring before 65 and have a spouse and/or dependents relying on your health plan for their own coverage, consider the impact of your choices on these individuals.

■ If spouse/dependents are still working, they may be covered by their own employment-related benefits, and that plan may become primary if yours no longer covers them.

■ If spouse/dependents are retired or disabled, or working but over age 65, they may be eligible for Medicare.

■ If spouse/dependents are *not* yet 65 and *not* eligible for Medicare, COBRA is one option (*see COBRA section in next column*).

■ If they prefer to purchase other coverage, there is [general information on other options on pages 13-15](#) (see “Is your employer plan enough?” and “Alternatives to employment-related benefits”)

■ If you do continue on your employer’s plan, and your spouse/dependents are covered, it is also important to consider how your death would affect their coverage. This is a concern regardless of when you retire. [See “Survivorship Issues” on page 17 for more details.](#)

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 federally mandates extension of group medical benefits to employees and their dependents under certain circumstances called “qualifying events.”

Qualifying events include:

1. Death of the covered employee;
2. Termination of employment, or reduction of hours to the point where the employee is no longer qualified for benefits;
3. Divorce/legal separation from the covered employee;
4. Entitlement to Medicare benefits by the covered employee. (Medicare entitlement ends COBRA coverage for the worker, but coverage is extended up to 36 months for spouse and/or dependent[s].) Coverage by any other group insurance also ends COBRA benefits.

The qualified beneficiary may be required to pay the entire premium cost, including the employer and employee contribution to the plan, but may not be charged more than 102% of the regular rates charged to plan members.

More information on COBRA benefits may be obtained by calling the U.S. Department of Labor Benefit Plans Office at (206) 553-4244.

It is also important to note that while there was a time when COBRA was a crucial protection for workers ending their employment before 65, changes in state and federal individual insurance laws have decreased COBRA’s necessity by extending eligibility for other kinds of insurance. It is now more effective for many people to shop around for the most cost-effective insurance rather than automatically extend their coverage under COBRA.

Health care reforms and the open insurance market

In July 1994, Insurance Commissioner Deborah Senn implemented a series of insurance reforms to enhance consumer protection. These reforms made the open health insurance market more accessible for many residents, including individuals retiring before age 65 and their dependents. As a result of the new laws:

- Washington became the first state to eliminate health screening. Insurers are barred from excluding applicants on the basis of health, and may not use waiting periods of more than 90 days to delay coverage for a pre-existing condition. Insurers must also sell coverage at current rates, and cannot create new high-risk rates.

- Health insurance can only be canceled if you stop paying your premium or commit fraud.

- Health insurance became “portable” (easier to maintain when switching jobs or changing insurance companies for other reasons). The portability rules prohibit insurance companies from creating obstacles to coverage for people who already have insurance, or who have had coverage within the previous three months.

In addition, the legislature made the state-administered Basic Health Plan is available to any resident. Premiums are adjusted on a sliding scale.



DISABILITY ISSUES

Employed persons who are eligible for Medicare due to disability may be covered by an employer’s health benefit plan (their own or that of a family member).

Medicare is the secondary payer for disabled people who have premium-free Medicare Part A and have health coverage through their own or a family member’s current employment. This applies to group health plans of employers with 100 or more workers.

Disabled individuals should contact the Social Security Administration with questions about eligibility and enrollment. In particular, if coverage ends or changes due to a change in employment by the covered worker, be sure to contact Social Security about enrolling in Medicare Part B. [For more information on Medicare enrollment in this Guide, see pages 9-12.](#)

Disabled residents who are *not* eligible for Medicare qualify under Washington state’s new reform laws (*summarized at left*) to purchase health insurance from any insurance company or managed care provider in Washington state. Neither age nor disability are factors if the resident is *not* eligible for Medicare.

Though some of the other options traditionally used in this circumstance are still available, regular health insurance is now a better bet in many cases, as the reforms guarantee eligibility regardless of pre-existing conditions.

R etiring **AT** age 65

If you are not going to continue to work after age 65, you need to apply for Medicare. The only reason not to sign up for Medicare is if you continue to be covered by a plan based on your own or a spouse's *current* employment.

When you retire at age 65, Medicare enrollment is fairly straightforward—but it is still important to understand how the process works.

In addition, you will need to consider how to supplement or enhance your Medicare coverage, since Medicare alone is not enough for most people.

These issues will be covered in this section as well as the next two sections:

- **Initial enrollment period for Medicare Parts A (Hospitalization) & B (Medical)**
- **Special enrollment period for Medicare Part B (Medical)**
- **General enrollment period for Medicare Part B (Medical)**
- **Supplementing/enhancing Medicare with other coverage**

Initial Enrollment Period

The initial enrollment period for Medicare Parts A and B spans the period starting three months before your 65th birthday and ending three months after your 65th birthday.

If you apply for Social Security retirement benefits prior to age 65, you should automatically get a Medicare card in the mail before your 65th

birthday. This card lets you know that you have been automatically enrolled in Medicare—both Part A and Part B—and provides you with an opportunity to delay your Part B coverage by returning the card with the appropriate box(es) checked.

It is very important to note that:

■ While you *should* receive your Medicare card in the mail and be automatically enrolled if you have applied for Social Security retirement benefits prior to retiring at 65, *do NOT assume that this has been done if you do not receive the card!* Mail problems or administrative errors can happen. If you have applied, call your local branch of the Social Security Administration.

■ If you do receive the card, you are automatically enrolled in both Part A and Part B *unless you return the card specifically requesting to delay enrollment*. If you are *not* retiring at 65 and have legal reasons to delay your enrollment in Part B (as detailed in the next section, **“Retiring AFTER Age 65”** starting on page 11) *you must return the card to indicate this*, or you will be automatically enrolled.

■ If you do *not* sign up for Social Security before or at age 65, you *will not* receive a Medicare card in the mail. In this case, it is up to you to initiate your enrollment. You will need to call Social Security to obtain the appropriate applications for Medicare enrollment. *See “Resources” in back for ways to contact Social Security.*

Enrollment in Part A (Hospitalization) at 65

Generally, people age 65 and over can receive premium-free Medicare Part A benefits based on their own or their spouse's employment. There is a premium for Part A for individuals who have less than 40 quarters of Social Security coverage. This premium can be quite high. [Call Social Security](#) (see *Resources* on back cover) for more information.

Enrollment in Part B (Medical) at 65

The initial enrollment period for Medicare Part B is a seven-month period: the three months before the 65th birthday, the month of the 65th birthday, and three months after the 65th birthday (see chart below).

The Part B premium changes every January.

A person may enroll in Part A, but choose to delay enrollment in Part B (Medical) *if they or their spouse are employed and covered by an employer's group medical benefit plan.*

If you are not covered by an employer's health plan, and you do not enroll in Medicare during the initial enrollment period, you are subject to a 10 percent penalty for each 12-month period you delay enrollment. This penalty applies to Part B premiums, as well as to Part A premiums if you are subject to Part A premiums. In addition to the premium penalty, your effective date for coverage will be delayed until July 1 of the year in which you do enroll.

If you enroll during the last four months of this period (the month of your 65th birthday or three months after), your Part B will start one to three months after you enroll (whereas when you enroll in the first three months of this period, Part B is effective the first day of the month you turn 65). Don't delay enrollment if you want Medicare to start as soon as you turn 65.

If you do not retire at age 65 and do not enroll in Medicare at age 65, as described on these two pages, there are other enrollment periods during which you can enroll in Medicare Parts A and B. These are detailed in the next section.

INITIAL Enrollment Period (Parts A or B)

INITIAL ENROLLMENT IS A 7-MONTH PERIOD

- the three months before the month of the 65th birthday
- month OF the 65th birthday
- the three months after the month of the 65th birthday

Mo. 1	Mo. 2	Mo. 3	Mo. 4 Month of 65th Birthday	Mo. 5	Mo. 6	Mo. 7
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R etiring AFTER age 65

Many people think of Medicare and age 65 as being necessarily related. However, they are not synonymous for people who continue to work after age 65. One of the most important and potentially confusing issues for individuals who continue to work after age 65 is when to enroll in Medicare. Should you wait until you stop working, or enroll as soon as you turn 65?

Enrollment in Part A (Hospitalization) after 65

Most people age 65 and over can get premium-free Medicare Part A benefits based on their own or their spouse's employment.

If you are still employed and have not applied for Social Security retirement benefits, *you must file a special application* to enroll in Medicare Part A. You will *not* be automatically enrolled.

Even if you continue to work and are covered by an employer's medical plan, enrolling in Medicare Part A assures you of those benefits if your employer's plan does not cover all of a hospital bill. The employer's plan will be primary, but Medicare Part A as a secondary payer may cover at least part of a balance after your employer's plan has paid its part.

If you do not have enough work credits to be eligible for premium-free Medicare Part A, or are a resident alien, you may obtain Part A by paying a monthly premium. This premium changes in January of each year.

Enrollment in Part B (Medical) after age 65

If you are covered by an employer's plan **based on your own or your spouse's *current* employment (*not* a plan for *retirees* and their spouses)**, you are eligible for a **Special Enrollment Period**. This means you can delay enrollment in Medicare Part B without penalty and don't have to wait for a General Enrollment (see next page).

You can enroll any time while still covered by the employer plan, or up until eight months after the month that you are no longer actively employed and/or no longer covered by an employer-related health plan.

If you file while you are still employed or covered by a plan based on spouse's current employment, the Special Enrollment can be filed in advance of the month that you want your Part B (or Premium Part A, if applicable) to begin. You can choose to have coverage begin in some future month (e.g., after employer's plan ends).

If you enroll after retirement/termination of the employer plan (during the eight-month period that follows), your Part B effective date depends on which month you enroll. If you file in the first month of the eight-month period, your Part B is effective that month. If you file in any of the remaining seven months, your Part B is effective the month after the one during which you filed.

SPECIAL ENROLLMENT PERIOD (Part B, Premium Part A)

ELIGIBILITY: PEOPLE WHO CONTINUE WORKING AFTER AGE 65 AND/OR ARE COVERED BY AN EMPLOYER'S PLAN BASED ON CURRENT EMPLOYMENT

THE SPECIAL ENROLLMENT PERIOD *INCLUDES* THE MONTHS DURING WHICH YOU ARE WORKING AND/OR COVERED BY EMPLOYER PLAN AFTER AGE 65, AND *CONTINUES* FOR EIGHT CONSECUTIVE MONTHS *AFTER*:

- the final month during which you were covered by an employer's plan (based on active employment) OR
- the final month during which you were still employed (*whichever comes first*)

MONTH OF TERMINATION	Mo. 1	Mo. 2	Mo. 3	Mo. 4	Mo. 5	Mo. 6	Mo. 7	Mo. 8
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If you continue working after 65 and can continue on your employer's plan, there are some compelling reasons to wait until retirement (or until the employer's coverage is about to end) before enrolling in Part B:

- Your employer's coverage may be broader than Medicare Part B.
- If you continue on the employer's plan, it will be primary (pay first). Medicare will pay *after* your group coverage has paid—if it pays at all. You'll be paying the Part B premium without receiving any benefits.
- Enrolling in Part B now will eliminate your Medigap open enrollment period opportunity. Under federal law, first-time Medicare Part B enrollees who are age 65 or older cannot be refused the right to purchase any Medicare supplement plan *within six months of initial enrollment in Part B*. This could offer significant protection when you leave the company plan if you purchase insurance on the open market. If you enroll in Part B *and*

continue coverage on your company plan for more than six months, you forfeit the opportunity to purchase the Medigap policy of your choice under this open enrollment provision. That could be a costly loss.

If you continue working, but discontinue coverage under the company plan, Medicare will become primary (pay first). You can then choose whether to cover the gaps in Medicare with an individual Medicare supplement, a managed care plan, or other plan.

The General Enrollment Period is for late enrollees—those who do not enroll during the **Initial** (at age 65) or **Special** (after age 65) enrollment. There are penalties for late enrollment: a permanent surcharge of 10% of the current premium for each 12-month period of late enrollment, and a waiting period before Medicare Part B coverage becomes effective. Open enrollment takes place during January, February, and March of each year; coverage is delayed until July 1st of that year.

GENERAL Enrollment Period (for late enrollees)

JAN.	FEB.	MAR.	APR.	MAY.	JUN.	JUL.	AUG.	SEP.	OCT.	NOV.	DEC.
OPEN ENROLLMENT						July 1st coverage begins					

ISSUE E.

Does my employer's plan fill Medicare's gaps?

Once you are enrolled in Medicare—at or after the age of 65, whether or not you continue to work—one of your concerns is obtaining health coverage that pays for what's *not* covered by Medicare. At this point, it's important to examine your employment-related benefits and see if they provide the features you need to supplement Medicare. If not, you'll want to investigate other options.

Medicare doesn't cover all health care costs

When it was enacted in 1965 as part of the Social Security Act, Medicare's purpose was to increase access to health care and reduce its financial burden on older, retired or disabled Americans. Medicare was never intended to pay 100 percent of all medical bills, but to offset the most pressing medical expenses for seniors and people with disabilities by providing a basic foundation of benefits.

Medicare benefits are divided into two parts:

- Part A (Hospital Insurance)
- Part B (Medical Insurance)

Part A provides substantial hospital care benefits, *extremely limited* coverage for skilled nursing care, limited rehabilitative and home health care services after hospitalization, and hospice care for the terminally ill. It does *not* pay for any personal or custodial care (e.g., help with eating, dressing, walking and bathing).

Part B helps pay for medical and surgical care, diagnostic tests and procedures, and a variety of other medical services and supplies. It does *not* cover most preventive or routine services, such as dental care, prescription drugs, acupuncture, foot care, eye examinations, eye-glasses, hearing aids, and other services not related to treatment of illness or injury.

Thus, while it provides considerable support, *Medicare does not cover all services that you might need.* Even those that are covered are not covered in full. There are deductibles; coinsurance; and with some physicians, charges over and above the allowed charge—what Medicare considers reasonable and necessary. Medicare will not pay above that limit.

The bottom line is that Medicare coverage alone leaves you with considerable fees and out-of-pocket expenses because of deductibles, coinsurance and services not covered.

Is your employer plan enough?

Most Medicare recipients need some kind of plan, policy or program to fill the gaps in Medicare's basic coverage. This can be done with:

- **employment-related benefits;**
- a managed care plan;
- private insurance, called a Medigap policy.

Alternatives to employment-related benefits

Retired or pre-retiree consumers who do not have employment-related benefits either themselves or through a spouse; who find their employer plans lacking in specific desired benefits, or who find their employer plans too costly, may want to investigate other options. In some cases, there are alternatives which might provide better or more appropriate benefits; be more cost-effective; or coordinate with Medicare more to your advantage.

No system of enhancing Medicare coverage is right for everyone. All have benefits and limitations which must be evaluated relative to your lifestyle and personal preferences. That's why it is important to analyze the coverage you do have, decide if you need more, and compare your options to determine the best one for you.

There are two easy-to-use analysis and comparison forms included in this Guide, on pages 18-19. One is for evaluating your employer plan by itself, and the other is for comparing your employer plan to other types of coverage, such as Medigap policies or managed care.

Once you understand the pros and cons of employer plans in general and have analyzed your particular benefits, you can compare your employer benefits to the other options available to you. A local SHIBA volunteer can assist you free of charge, helping you understand, analyze and compare plans. Call 1-800-397-4422.

Keep in mind that employment-related benefits may include either of two common coverage options described below: a managed care plan or a supplement policy. Many employers design, or contract for, their own private

versions of these *types* of plans. *In these cases, coverage is not subject to the same rules and standards that the federally-regulated Medigap plans and Medicare-contracting managed care plans are.*

Managed Care Plan

The growth of managed care has made it a viable choice for Medicare beneficiaries to fill Medicare gaps and enhance their coverage.

A Medicare beneficiary has the option of receiving Medicare services through a Medicare-contracting managed care provider, *if one is available in your area*. (These plans generally cover you only in specific service areas, except for emergencies.)

For more detailed information on how managed care works with Medicare, get the SHIBA publications titled *Managed Care, Medicare and You*, and *Managing Your Managed Care* ([see order form in back of Guide](#)).

Medicare Supplements

People without employment-related benefits might choose a Medicare supplement—usually called a “Medigap” policy. These are private insurance policies created specifically to fill Medicare's gaps.

In 1992, federal regulations set uniform standards for these policies, and now there are 10 standard plans (Plan A through Plan J). Each offers a different group of benefits to fill a different set of Medicare gaps. SHIBA's *Medicare, Medigap and You* has more information on these, including a chart detailing the coverage provided by each of the 10 plans ([see order form in back of Guide](#)).

Open Enrollment for Medicare Supplement Insurance (Medigap Policy)

Within 6 months of first-time enrollment in Medicare Part B (Medical) at age 65 or older, any Medigap policy may be purchased regardless of pre-existing conditions or evidence of insurability.

Medicare Part B Enrollment Date	Mo. 2	Mo. 3	Mo. 4	Mo. 5	Mo. 6
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Medigap Enrollment

The open enrollment period for Medigap policies (sometimes called Medicare supplements) is for those who are interested in buying one of the ten standardized A - J policies. For an individual age 65 or over, this six-month open enrollment period begins when they enroll in Medicare Part B for the first time. (As of January 1, 1995, this is true for disabled Medicare beneficiaries at age 65, even if they were on Medicare before age 65. See “Disability Issues” at right.)

Any time within the first six months after enrolling in Medicare Part B for the first time, the client may purchase any Medigap policy without medical screening or underwriting based on health or pre-existing conditions. (However, policies may still use waiting periods for pre-existing conditions.)

If purchasing a Medigap policy *after* the open enrollment, companies may impose a waiting period of up to 90 days before pre-existing conditions will be covered by the policy.

If you enrolled in Part B, dropped out, and enroll again, the open enrollment period for a Medigap policy does *not* apply.



DISABILITY ISSUES

Disabled individuals turning 65 can now take advantage of an open enrollment period for Medicare supplements *even if they are not enrolling in Medicare Part B for the first time.*

This does *not* extend open enrollment to persons *under* age 65. It does, however, give individuals a six-month window for choosing any Medigap policy, and allows persons previously excluded from this open enrollment to enjoy the same benefits that first-time Medicare Part B enrollees have had (no medical screening or underwriting based on health or pre-existing conditions).

The Medigap open enrollment is not available to people who have Medicare based on disability or end-stage renal disease. However, at age 65, the basis for Medicare always switches to age, and open enrollment becomes available to these beneficiaries at age 65 *even if they are not enrolling in Medicare Part B for the first time.*

For more information on Medicare, Medigap policies, and disabilities, consult with a local SHIBA volunteer. [See the back of this Guide for details on contacting SHIBA.](#)

What should I look for in my employer's plan?

The specific features and benefits you demand from your health insurance will depend not only on your individual health status and history, but also on where you are in the retirement process and whether or not you will continue to work after 65 (because this affects when and whether you sign up for and receive Medicare coverage).

If you are covered by Medicare, like most people you will probably want something to cover the services that Medicare doesn't. You may want your employment-related benefits to fill such gaps as dental care, prescription drugs, preventive care or other desirable services (see charts on page 18-19). If your employer plan doesn't cover what you want, consider other options.

Other important features in a health plan are a **stop loss benefit** and **lifetime maximum**.

Stop loss is an out-of-pocket expense limit that minimizes your responsibility for out-of-pocket expenses after a certain point. Plans with this feature will pay 100% of plan-approved charges (not paid by Medicare) after the retiree has paid a deductible and reached a specified out-of-pocket ceiling.

For example, after the calendar year deductible is met, an employer's plan might cover 80% of allowed charges (after Medicare's payment) until the covered patient has paid \$1,000 out-of-pocket. After that, the plan pays 100% of covered charges that Medicare does not pay.

A plan's **lifetime maximum** should be compared with that of other plans. Some plans put a ceiling on the total benefits they will pay over the covered person(s)' lifetime. This fixed limit may be significantly lower for retirees than for active employees. There may be an option to renew the limit after a period of good health and no continuing expense.

How does the plan pay?

One of the most important considerations, regardless of what coverage combinations you rely on, is the issue of benefit coordination.

There are two basic types of benefit coordination in health insurance plans (though others exist):

In a **wraparound** plan, the plan pays a percentage of the *balance* after Medicare pays its 80 percent of approved charge. Thus if Medicare pays 80 percent, or \$800, of a \$1,000 doctor bill, the plan pays a *percentage* of the remaining \$200 balance.

In the more common **carve-out** plan, the plan pays a fixed percentage of the usual/customary charge, *less Medicare's payment* (i.e. Medicare benefits are "carved out" of the plan benefit). This often leaves you with a significant portion of the bill: the balance after Medicare's payment, *plus* the amount over and above the usual/customary charge (if any) that Medicare does not pay.

DOES YOUR EMPLOYER'S PLAN COVER these benefits not covered by Medicare?

- DENTAL CARE
- PRESCRIPTION DRUGS
- VISION CARE
- FOOT CARE
- HEARING
- OUT-OF-U.S. COVERAGE
- PREVENTIVE CARE
- SOME REHABILITATION
- ALTERNATIVE MEDICINE
- DRUG/ALCOHOL TREATMENT

If your plan is a carve-out plan, this is how it would work with the same doctor bill from the earlier example: Medicare would pay its 80% (\$800) of the bill. The employer plan benefit would be calculated as a percentage of the *total bill* (not the balance after Medicare's payment). If your plan's benefit is 80% of the doctor's bill, that's \$800—*minus Medicare's payment of \$800*. Thus the plan pays nothing. You pay the full \$200 balance after Medicare.

For assistance in determining how your plan works and calculating specific claims, contact SHIBA for an appointment with a volunteer. (See the last page of this Guide for information about SHIBA.)

Analyzing employment-related benefits

To analyze your employer's plan to see if it meets your needs given your retirement plans, you'll need a *current* copy of your plan's benefit booklet. Be sure that you have the most updated version. This can usually be obtained from an employer's human resources department or employee benefit coordinator.

Survivorship benefits

When analyzing your employer's plan, be conscious of how your decisions affect spouse/dependents who may be relying on your coverage. If you choose to keep your employer's plan even after you retire, or if you continue working after retirement and are covered by your employer's plan, it is important to consider how your spouse/dependents' coverage might be affected not only by your retirement, but also your death.

While you work, or even after retirement, your spouse/dependents may be covered by the employer plan you have kept. However, in many cases, the spouse/dependents no longer have coverage after the covered worker dies if they are not receiving pension benefits based on the covered worker's employment.

Use the checklist on the next page to illustrate for yourself the benefits and limitations of your plan—now and possibly for the future. Again, for help understanding your benefit booklet, your claims, or your options, contact a SHIBA volunteer. Call 1 (800) 397-4422.

Employment-Related Benefit Plan Review

SOME THINGS TO CONSIDER ABOUT YOUR EMPLOYMENT-RELATED BENEFIT PLAN

Does the employer's plan continue after retirement? _____

Does the plan appear to be secure, or is the employer cutting back on benefits? _____

Does the plan cover the retired person's spouse or other dependents? _____

Will the spouse/dependent be covered if the retired person dies? _____

What are the lifetime maximums in the employer's plan? _____

How much of the lifetime maximums have been used? _____

What are the deductibles or co-payments/coinsurance of the employer's plan? _____

Hospital deductible or co-payment/coinsurance _____

Emergency room or hospital outpatient deductible or co-payment _____

Medical deductible or co-payment/coinsurance _____

Other deductibles or co-payments/coinsurance _____

Does the employer's plan provide dental, eyeglass, hearing or other coverages? _____

Does the plan require the use of participating providers? _____

If so, will the plan beneficiaries continue to live in the service area? _____

Does the plan provide a prescription drug benefit? How does it work? _____

Is there a stop-loss or out-of-pocket limit? _____

How much does the employer's plan cost per month? _____

FOR ASSISTANCE IN CALCULATING YOUR SPECIFIC BENEFITS AND, IF APPLICABLE,
THEIR COORDINATION WITH MEDICARE, CONSULT A SHIBA VOLUNTEER.
CALL (800) 397-4422.

COMPARING ALL PLANS

BENEFIT	OUT-OF-POCKET MAXIMUM			
	NAME OF PLAN	NAME OF PLAN	NAME OF PLAN	NAME OF PLAN
Hospital Deductible				
Medical Deductible				
Hospital Co-payments				
Medical Co-payments				
Annual Out-of-Pocket Limit				
Prescription Drugs				
Foreign Travel/Out of Area				
Monthly Premium				
Preventive Care (besides flu shots, mammograms)				
Lifetime Benefit Maximum				
OTHER _____ (Eye exam, glasses, hearing aids)				

Long-Term Care: The Other Retirement Planning

Medicare does not cover long-term care; Medicare supplements do not cover long term care; and managed care plans do not cover long term care. Employer plans cover little if any long-term care. Therefore, it is a good idea to give some thought to your potential long-term care needs and how you might pay for them.

This section provides a *brief* overview of long-term care and the options for covering it. For detailed information, consult SHIBA's free *Consumer's Guide to Planning for Long-Term Care* and *Did You Forget Something?*, and the free National Association of Insurance Commissioners' (NAIC) *Shopper's Guide to Long-Term Care Insurance* (see "[Resources](#)" on back cover). You may also meet with a SHIBA volunteer who can help you learn more, evaluate your risks, and understand your options.

What is long-term care?

Long-term care is the range of medical and social services provided to people with chronic or prolonged illnesses, disabilities, or cognitive impairments. In the U.S., the incidence of chronic illness and disability increases significantly with age, and among Americans over 65 there is a greater statistical risk of such illness than for the accidents or other disasters we typically insure against.

While people often think of long-term care as strictly nursing home care, the term actually refers to a variety of care situations and services. Among them are home health care, assisted living, adult day care, custodial care, continuing care retirement communities, hospice care, physical therapy and more. Few of these services are covered by Medicare or any other general medical insurance policy or plan.

What are your options for paying for long-term care?

There are three main ways to pay for long-term care: self-pay (out of pocket); long-term care insurance; and Medicaid (for the impoverished). Some of these involve a variety of options (such as trusts, annuities, or other special investments for self-pay). There are also other less common options. See SHIBA's *Consumer's Guide to Long-Term Care Planning* for a detailed explanation of all major long-term care payment options and long-term care services.

The chart on the next page explains benefits and potential disadvantages of each of the basic strategies. For more information about these and other options, or for assistance in determining whether you are a good candidate for long-term care insurance, consult a SHIBA volunteer for a free, impartial consultation. See the back page of this Guide for more information on SHIBA.

COMMON WAYS TO PAY FOR LONG-TERM CARE

	WHAT IT IS	POSSIBLE PLUSES	POSSIBLE MINUSES
Self-Pay (savings, family money, trusts, annuities, reverse mortgages, other investments)	If you need long-term care services, you pay for all services 100% out of pocket. This can be done by using cash/savings, income-producing investments, or other strategies.	If you never do need long-term care, you have paid nothing out of pocket.	If it turns out that you do require long-term care, the expenses could overwhelm you and/or your family and exhaust nearly all resources. Nursing homes can cost \$4,000 to \$5,000 per month, and home care can be even more costly.
Insurance	A private insurance policy that may be purchased for protection against possible long-term care expenses. In Washington State, all policies are guaranteed renewable and cover all forms of mental and emotional as well as physical disorders.	If you select the right policy for you, you can protect yourself, your family and your assets against the financial and practical burdens of providing long-term care in the event that you require it. The cost of a policy buys peace of mind, and can be minor compared with potential out-of-pocket costs.	If you never need long-term care, the cost of insurance will have exceeded any out-of-pocket expenses for long-term care.
Medicaid	A state and federal aid program that may pay all or part of long-term care costs for individuals who are categorically eligible (by reason of financial need based on income and asset levels).	If your income and asset levels are already at or near the qualifying levels, you can get coverage if you need it.	If your income and asset levels are <i>not</i> already at or near the qualifying levels, you will have to "spend down" (exhaust your assets) to those levels before you can receive assistance.

IF YOU NEED MORE HELP...

SHIBA is an impartial, confidential resource to help you evaluate, choose and use your health insurance. A statewide network of trained volunteers stands ready to educate you on health insurance issues, so you can make informed decisions.

Our highly trained volunteer counselors have up-to-date information on all health insurance concerns. They can answer your questions and assist with insurance planning.

Their services are FREE. And they have no affiliation with any insurance company or product.

SHIBA was the first senior health insurance peer counseling program in the nation, and is now a model for the rest of the United States.

There's a **SHIBA** unit in nearly every county in Washington State. Call today to get the number of the SHIBA sponsor nearest you.

1-800-39-SHIBA
(1-800-397-4422)

RESOURCES

HOTLINES, ORGANIZATIONS

- For consumer brochures about health insurance, and referral to nearest local SHIBA office: SHIBA Hotline / (800) 397-4422
- With all other insurance questions/comments/suggestions (*auto, life, homeowner, etc.*): Insurance Commissioner Deborah Senn's Consumer Hotline / (800) 562-6900
- Health Care Financing Administration (HCFA)
Consumer Services (206) 615-2354 Medicare Hotline (800) 638-6833
Medicare Managed Care (206) 615-2351
- Medicare Part A & B Intermediaries & Carriers
Blue Cross Part A Fiscal Intermediary (206) 670-1010
Mutual of Omaha Part A Fiscal Intermediary (402) 351-2860
Blue Cross Blue Shield of North Dakota - Part B Carrier (800) 444-4606
Peer Review Organization (PRO) (206) 368-8272, (800) 445-6941
- Social Security Administration (800) 772-1213
- Senior Information and Assistance
National Elder Care Locator Service (800) 677-1116
- With questions about COBRA:
U.S. Dept. Of Labor Benefits Office (206) 553-4244

PUBLICATIONS

- *The Medicare Handbook*
Health Care Financing Administration (HCFA) (800) 638-6833
6325 Security Boulevard, Baltimore, MD 21207
- *Guide to Health Insurance for People w/Medicare*
- *Medicare and Other Health Benefits*
- *Medicare and Coordinated Care Plans*
- *Medicare: Hospice Benefits*
Consumer Information Center, Pueblo, CO 81009
- *A Shopper's Guide To Long-Term Care Insurance*
National Association of Insurance Commissioners (NAIC)
Publications Dept., 120 West 12th Street, Suite 1100
Kansas City, MO 64105

TO ORDER CONSUMER PUBLICATIONS FROM THE OFFICE OF INSURANCE COMMISSIONER DEBORAH SENN, USE THE ORDER FORM ON THE NEXT PAGE.



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☐

SHIBA General Info Brochure (Trifold)

(please check only those you wish to receive)

☐

Medicare, Medigap and You

☐

Managed Care, Medicare and You

☐

Managing Your Managed Care

☐

Retirement and Your Health Insurance

☐

Health Insurance Fraud Costs You

☐

Did You Forget Something? A Look at Planning for Long-Term Care

☐

The Consumer's Guide to Long-Term Care Planning (scheduled publication 7/97)

☐

Please send information on becoming a SHIBA volunteer.

☐

I'm interested in having a speaker for my group. Please call me.

Name of group _____

Size of group (audience) _____

Phone number _____

SEND THIS
FORM TO:

Office of the Insurance Commissioner
Deborah Senn, Insurance Commissioner
SHIBA - Publications
P.O. Box 40256
Olympia, WA 98504-0256

FOLD THIS FORM AND PLACE IN
ENVELOPE USING ADDRESS AT LEFT



1-800-397-4422

SHIBA (Statewide Health Insurance Benefits Advisors)
Office of the Insurance Commissioner
P.O. Box 40256
Olympia, WA 98504-0256

Retirement & Your Health Insurance

is part of the consumer information series

published by The Office of the Insurance Commissioner

SEE ALSO:

- ▶ Medicare, Medigap & You
- ▶ Managed Care, Medicare & You
- ▶ Managing Your Managed Care
- ▶ Did You Forget Something? (Long-Term Care Partnership)
- ▶ Consumer's Guide to Long-Term Care Planning
- ▶ Health Insurance Fraud Costs *You*

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